
Agency*	Citation(s)	Groups Covered
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The payment levels under the approved State AFDC plan are no lower than the AFDC payment levels in effect under the approved AFDC plan on April 17, 1986.

☒ Yes.

☐ Not applicable. The State does not provide coverage of this optional categorically needy group.

1902(a)
(10)(A)
(ii)(X)
and 1902(m)
(1) and (3)
of the Act,
P.L. 99-509
(Section
9402(a) and
(b))

___ 14. In addition to individuals covered under item B.13, individuals--

(a) Who are 65 years of age or older or are disabled--

___ As determined under section 1614(a)(3) of the Act; or

___ As determined under more restrictive categorical eligibility criteria specified under item A.9(b) of this Attachment.

(b) Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal nonfarm income poverty line) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and

(c) Whose resources do not exceed the maximum amount allowed--

___ Under SSI;

___ Under the State's more restrictive financial criteria; or

___ Under the State's medically needy program as specified in ATTACHMENT 2.6-A.

*Agency that determines eligibility for coverage.

TN No. 87-15
Supersedes
TN No. _____

Approval Date JUL 14 1987

Effective Date 7-1-87

HCFA ID: 1036P/0015P

Agency*	Citation(s)	Groups Covered
	1902(a)(47) and 1920 of the Act, P.L. 99-509 (Section 9407)	<input checked="" type="checkbox"/> 15. Pregnant women who meet the applicable income levels for the categorically needy specified in this plan under <u>ATTACHMENT 2.6-A</u> who are determined eligible by a qualified provider during a presumptive eligibility period in accordance with section 1920 of the Act.
		C. <u>Optional Coverage of the Medically Needy</u>
435.301		This plan includes the medically needy. <input type="checkbox"/> No. <input checked="" type="checkbox"/> Yes. This plan covers: 1. Pregnant women who, except for income and resources, would be eligible as categorically needy.

*Agency that determines eligibility for coverage.

TN No. 89-4
Supersedes
TN No. 87-15

Approval Date OCT 10 1989 Effective Date 2-1-89

HCFA ID: 1036P/0015P

Received 3/23/89

State: Tennessee

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

- _____ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- _____ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- _____ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- _____ (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
- _____ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
- _____ (9) Individuals in additional classifications approved by the Secretary as follows:

*Agency that determines eligibility for coverage.

No. 92-6
supersedes
TN No. NEW

Approval Date 6-2-92

Effective Date 1/1/92

HCFA ID: 7983E

Revision: HCFA-PM-91-4 (BPD)
1991

ATTACHMENT 2.2-A
Page 18a
OMB NO.: 0938-

State: Tennessee

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

_____ Yes

_____ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

*Agency that determines eligibility for coverage.

No. 92-6
persedes
TN No. NEW

Approval Date 6-2-92

Effective Date 1/1/92

HCFA ID: 7983E

State: Tennessee

Agency* Citation(s) . Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.231 /X/ 12. Individuals who are in institutions for at
1902(a)(10) least 30 consecutive days and who are
(A)(ii)(V) eligible under a special income level.
of the Act Eligibility begins on the first day of
the 30-day period. These individuals
meet the income standards specified in
Supplement 1, page 9a. to ATTACHMENT 2.6-A.

/X/ The State covers all individuals as described
above.

/ The State covers only the following group or
groups of individuals:

1902(a)(10)(A)
(ii) and 1905(a)
of the Act

_____ Aged
_____ Blind
_____ Disabled
_____ Individuals under the age of--
_____ 21
_____ 20
_____ 19
_____ 18
_____ Caretaker relatives
_____ Pregnant women

*Agency that determines eligibility for coverage.

No. 92-6
persedes
TN No. 87-15(page 17)

Approval Date 6-2-92

Effective Date 1/1/92

HCFA ID: 7983E

State: Tennessee

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(e)(3) / 13. Certain disabled children age 18 or
of the Act under who are living at home, who
would be eligible for Medicaid under the plan
if they were in a medical institution, and for
whom the State has made a determination as
required under section 1902(e)(3)(B) of the
Act.

Supplement 3 to ATTACHMENT 2.2-A describes the
method that is used to determine the cost
effectiveness of caring for this group of
disabled children at home.

1902(a)(10) /X/ 14. The following individuals who are not
(A)(ii)(IX) mandatory categorically needy whose income
and 1902(1) does not exceed the income level (established
of the Act at an amount above the mandatory level and
not more than 185 percent of the Federal poverty
income level) specified in Supplement 1 to
ATTACHMENT 2.6-A for a family of the same size,
including the woman and unborn child or infant
and who meet the resource standards specified in
Supplement 2 to ATTACHMENT 2.6-A:

- a. Women during pregnancy (and during the
60-day period beginning on the last day of
pregnancy); and
- b. Infants under one year of age.

*Agency that determines eligibility for coverage.

No. 92-6
Supersedes
TN No. 87-15 & 91-36(pages 17 & 17a)

Approval Date 6-2-92

Effective Date 1/1/92

HCFA ID: 7983E

Revision: HCFA-PM-91-4 (BPD)
1991

ATTACHMENT 2.2-A
Page 21
OMB NO.: 0938-

State: Tennessee

Agency*	Citation(s)	Groups Covered
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NOT APPLICABLE

*Agency that determines eligibility for coverage.

No. 92-6
Supersedes
TN No. 91-36 (page 17a)

Approval Date 6-2-92

Effective Date 1/1/92

HCFA ID: 7983E

State: Tennessee

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a) /
(ii)(X)
and 1902(m)
(1) and (3)
of the Act

16. Individuals--

- a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.
- b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and
- c. Whose resources do not exceed the maximum amount allowed under SSI; or under the State's medically needy program as specified in ATTACHMENT 2.6-A. Supplement 2, pg. 6

*Agency that determines eligibility for coverage.

No. 92-6
persedes
TN No. 87-15(page 17b)

Approval Date 6-2-92

Effective Date 1/1/92

HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: TENNESSEE

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a)(47)
and 1920 of
the Act

- X 17. Pregnant women who are determined by a "qualified provider" (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.

TN No. 92-23

Supersedes

TN No. 92-6

Approval Date

7/27/92

Effective Date

4/1/92

State/Territory: Tennessee

Citation

Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

- | | | | |
|--|----------|-----|--|
| 1906 of the Act | <u>/</u> | 18. | Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of _____ months. |
| 1902(a)(10)(F) and 1902(u)(1) of the Act | <u>/</u> | 19. | Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A. |

*Agency that determines eligibility for coverage.

Rev No. 92-6
Supersedes
TN No. NEW

Approval Date 6-2-92

Effective Date 1/1/92

HCFA ID: 7983E